Application for Essential Community Provider Trust Fund Grant
Instructions for Completion
7-13-2007

The application for essential community provider trust fund grants can be found on the Executive Office of Health and Human Services (EOHHS) website at www.mass.gov/eohhs or the Division of Health Care Finance and Policy's (DHCFP) website at www.mass.gov/dhcfp. It should be completed by any hospital or community health center that believes it meets the criteria outlined in the grant cover letter (available online), which was mailed to each facility.

This application is an Excel worksheet that should be downloaded and completed by each applicant. The application should be completed in its entirety and e-mailed, as an attachment, to an e-mail to kevin.flynn@state.ma.us **no later than** 4:00 p.m. on Tuesday, July 31, 2007. **Please DO NOT change the form, since the data will be copied and pasted to a separate workbook for comparative analysis.**

Applicants SHOULD INPUT DATA ONLY IN THOSE CELLS THAT ARE BLUE (unless the instructions specifically request that the applicant provide additional data.)

Demographic data:
Enter the provider name and address in the labeled cells.

Contact information:
Enter the name, telephone number and e-mail address of the person whom EOHHS staff should contact with any questions that may arise during the analysis of the application.

Provider FYE:
Enter the date of the provider's fiscal year end.

Grant request:
Indicate the type of grant for which you are applying by entering an "X" into the appropriate box:
   A. Financially distressed provider
   B. Essential provider.

Compliance with filing requirements:
Indicate (yes or no) whether or not you have a. filed financial statements with the Division for the years 2005 and 2006 and b. whether or not our facility is current with all DHCFP filing requirements.

Enter the total amount of the grant monies that you are requesting in the box.

BRIEFLY describe the projects for which you are submitting a grant request and the amount for each project. E.g. Purchase CPOE software and supporting hardware, $125,000 or expand diabetes management program staff $65,000.

A word document limited to TWO printed pages may accompany the application as an e-mail attachment to describe the intended use of the funds, the timeline for the implementation of your grant project(s), and the outcome measures by which we can assess the success of the sponsored project. **This document must use 12 point font with 1" top and bottom margins and 1.25" left and right margins. Failure to adhere to these limits will negatively impact the assessment of your application.** A more detailed description can be provided when you submit the contract after the awards are made.

All applicants should complete questions 1-9.

Line 1.   Enter the percent of your clinical staff who can communicate in more than one language (e.g., 10%).

Line 2.   Enter the percent of the patients that your facility serves are of racial or ethnic minority (e.g., 10%).

Line 3.   Enter the percent of the population served by your facility that is non-English speaking e.g., 10%).

Line 4.   Enter whether or not your facility provides smoking cessation counseling services. (yes or no)

Line 5.   Enter whether or not your facility provides sexually transmitted disease counseling services. (yes or no)

Line 6.   Enter the percent of your patient population that suffers from substance abuse or mental health disorders (e.g., 10%).

Line 7.   Enter the percent of your patient population that is elderly, chronically ill or disabled (e.g., 20%).

Line 8.   Indicate whether or not physicians or other providers in your facility enter orders using a computerized system. (yes or no)

Line 9.   If you answered "no" in line 1, indicate whether or not your facility will have a computerized system for order entry in place by December 31, 2008. (yes or no)

Only acute hospitals should complete questions 10-12.

Line 10.   Enter the percent of the time that your facility notifies a MassHealth member's Primary care physician of an emergency room visit (e.g., 75%).

Line 11.   Enter the percent of your patient population that is referred to community-based services for non-emergent care pursuant to 114.6 CMR 12.00 (e.g., 5%).

Line 12.   Enter your facility's market share in your primary service area. This should consider your facility's number of beds, the number of available beds in your service area, and your competitive position (e.g., 30%).

Only Community Health Centers should complete questions 13- 20.

Line 13.   Indicate whether or not your facility has open scheduling to treats walk-in patients. (yes or no)

Line 14.   Indicate the number of hours during the week that walk-in patients are seen (e.g., 16 hours).

Line 15.   Indicate whether or not your facility has extended hours (before 9:00 a.m. and after 5:00 p.m.) Monday through Friday. (yes or no)

Line 16.   Indicate the number of hours, from Monday through Friday that your facility offers extended hours (e.g., 20 hours).

Line 17. Indicate whether or not your facility offers weekend hours. (yes or no)

Line 18. Indicate the number of hours that your facility is open on the weekend (e.g., 8 hours).

Line 19. Indicate whether or not your facility offers a program of all inclusive care for the elderly. (yes or no)

Line 20. Indicate whether or not your facility offers 24-hour emergency services. (yes or no)

All applicants should complete questions 21.

Line 21. Indicate any amounts that your facility received in fiscal 2005, 2006 and 2007 from the Distressed Provider Expendable Trust Fund or Essential Community Provider Trust Fund.

Line 21a. Indicate any funds that your facility received in 2006 or 2007 as a result of special appropriations by the legislature.

Line 21b. Indicate any amounts that your facility received in fiscal 2005, 2006 and 2007 from any other state grant program.

Financial Data

CHC applicants should complete financial data items 22-46. Hospital data will be taken from the March 31, 2007 quarterly filings.

Each applicant must enter their financial data for quarter ended March 31, 2007. Balance Sheet financial data should be March 31 amounts. Operating statement data should include year-to-date numbers. The Division will use cost report data to complete the entries for the prior periods.

Line 22. Cash and liquid investments: enter the amount of cash and cash equivalents (maturity of 90 days or less at acquisition).

Line 23. Board designated assets: enter the amount for assets that your facility's board of directors has limited the use of that would otherwise be available to fund current operations.

Line 24. Patient accounts receivable net of the allowance for doubtful accounts: enter the amount that represents amounts due and collectible from patients for services provided.

Line 25. Total current assets: enter total current assets from your balance sheet.

Line 26. Accumulated depreciation: enter the amount of depreciation that has been charged to expense for fixed assets according to your facility's depreciation policy. Exclude from this amount any amortization of assets that are not property plant and equipment.

Line 27. Total assets: enter the total asset amount from your balance sheet.

Line 28. Trade accounts payable: enter amounts due and payable to vendors that have provided goods and services to you.

Line 29. Total current liabilities: enter the total of liabilities due to be satisfied during the current operating cycle.

Line 30. Current portion of long term debt: enter the amount of long-term debt that will be paid in the current operating cycle.

Line 31. Long-term debt: enter the balance of long-term debt that is due in subsequent operating cycles.

Line 32. Unrestricted net assets: enter the total unrestricted net assets from your balance sheet.

Line 33. Temporarily restricted donations: enter the amount of temporarily restricted donations recorded for the reporting period.

Line 34. Permanently restricted donations: enter the amount of permanently restricted donations recorded for the reporting period.

Line 35. Net patient service revenue: enter amount of net patient revenue earned during the reporting period.

Line 36. Net operating revenue: enter the net revenue earned from operations for the reporting period.

Line 37. Total operating expenses: enter the total expenses charged to operations during the reporting period.

Line 38. Bad debt expense: enter the estimate of uncollectible revenue charged to expense during the reporting period.

Line 39. Interest expense: enter the total of interest on borrowed funds charged to operations during the reporting period.

Line 40. Depreciation: enter the amount of depreciation on property plant and equipment charged to operations during the reporting period.

Line 41. Amortization: enter the amount of amortization of long-term assets other than property plant and equipment charged to operations during the reporting period.

Line 42. Net income from operations: enter the difference of total operating revenue and total operating expenses for the reporting period.

Line 43. Unrestricted donations: enter the total unrestricted donations recorded for the reporting period.

Line 44. Expenditures for property plant and equipment: enter the amount expended for property plant and equipment for the reporting period.

Line 45. Interest in net assets: enter the amount of interest in net assets of other entities that your facility shows on its balance sheet.

Line 46. Other changes in unrestricted net assets: enter any other changes to unrestricted net assets recorded during the reporting period and describe in the appropriate line.

Line 47. Violations of Debt Covenants: indicate if your facility has been in technical default on any long-term debt at the end of any fiscal year from 2004 through 2006. (yes or no, and provide an explanation if you answer yes)

Line 47a. Material financial deterioration since March 31, 2007: If your facility has experienced a **material** change in financial position from March 31,2007 through the date of your

grant application filing please briefly describe the circumstances surrounding this change.

Payer Mix: All 4 columns should be completed by all applicants

Line 48. Gross patient service revenue: enter total gross patient service revenue for the requested periods.

Line 49. Medicare gross patient service revenue: enter total Medicare gross patient service revenue for the requested periods.

Line 50. Medicaid gross patient service revenue: enter total Medicaid gross patient service revenue for the requested periods.

Line 51. Gross receipts from the uncompensated care pool: enter the gross amount of receipts from the uncompensated care pool for the requested periods.

Line 52. For hospital applicants only: inpatient days; enter total inpatient days for the requested periods.

Line 53. Emergency Department visits: enter total emergency visits for the requested periods.

Line 54. CHC's only: CHC visits; enter total visits to the CHC for the requested periods.

Questions should be directed to Kevin Flynn at 617-988-3206.